

# **Understanding Brazilian Global Health Diplomacy: Social Health Movements, Institutional Infiltration, and the Geopolitics of Accessing HIV/AIDS Medication**

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*Global Health Diplomacy (GHD) is a new area of scholarly research. While much has been written on this topic, to date few have analyzed the social and political origins of GHD processes and their outcomes. Using the case of Brazil as illustration, in this article I carefully analyze the historical social and institutional conditions motivating nations to engage in intensive international negotiations for access to essential medicines. Moreover, this article maintains that scholars have failed to address how praises from the international community can create incentives for nations to sustain their commitment to not only international negotiations but also bi-lateral assistance to other nations.*

## **INTRODUCTION**

In recent years, scholars and health policy practitioners have become increasingly interested in analyzing the intersection of international relations and health policy-making. With increased international trade and communication, it is safe to say that health policy-making no longer operates in complete isolation from international influence, and relations between nations have often been shaped by domestic health policy interests. The term “Global Health Diplomacy” (GHD) has recently been used to capture this domestic-international dynamic, leading to a host of definitions and theories about what precisely this process entails.<sup>1,2,3,4</sup>

In light of this new literature, this article takes a closer look at the case of Brazil, its GHD activities, and its response to HIV/AIDS. While GHD scholars have addressed the reasons why nations engage in international negotiations for achieving health policy goals, the case of Brazil underscores limitations to this literature. The literature falls short in its discussion of the important role of historical social health movements, their infiltration into the national bureaucracy, coalition-building capacity and ability to help create institutions that

commit and incentivize governments to aggressively engage in international negotiations for access to essential medicines, such as antiretroviral (ARV) medication for HIV/AIDS. Findings from Brazil suggest that in order to better understand why nations vary in their ability to successfully engage in international negotiations, more research needs to be done analyzing and explaining the historic role of social health movements and their strategies for motivating politicians and diplomats to engage in this process.

In addition, while the GHD literature has focused on how governments create domestic and bilateral health policies as a means to achieve foreign policy goals, the case of Brazil suggests that this literature has overlooked the important role the international community plays in this processes. More specifically, evidence from Brazil suggests that international attention and praise for a nation's successful ability to engage in international negotiations may motivate government leaders to create bilateral policies with the objective of sustaining and furthering their government's international reputation and influence. Thus, future research will need to examine to what extent international attention and praise can catalyze and motivate governments to help other nations combat HIV/AIDS, as well as consider the causal significance of international attention and praise on ongoing domestic and bilateral health policy innovations.

While the case of Brazil may be unique in its historical preconditions, experiences, and commitments to ensuring medical treatment and care for HIV/AIDS, this should not preclude scholars from examining if similar causal processes and outcomes are present in other nations. If anything, the case of Brazil should motivate scholars to conduct more research on the historical social, political, and institutional preconditions for successful GHD processes, as well as the extent to which international responses and collaboration can deepen these processes.

In the next section, I discuss the methodological approach to this study. This is followed by a review of the recent literature conceptualizing and defining GHD processes, as well as its limitations. I then provide an in-depth case study of Brazil's international negotiations for accessing ARV medication, as well as the government's creation of bilateral initiatives towards Africa. I conclude with key lessons that the case of Brazil provides for GHD scholars, in addition to new areas of future research.

## METHODOLOGY

This study employed a qualitative methodological approach to research. The author used several primary and secondary pieces of literature, such as journal articles, policy reports, and books to conduct a literature review and to substantiate causal claims. In-depth interviews with politicians and health officials in Brazil were also conducted. Academic colleagues, activists, and retired health officials in Brazil recommended these individuals. Those that were interviewed were not selected for their particular views. This helped to avoid the biased selection of data. Interviews were done in person in Brazil and over the phone in the United States, from 2008 to 2010. Interviewees also gave consent to use their names and titles.

Brazil was selected because of the author's in depth knowledge of the case, fluency in the Portuguese language and easy access to health officials and data. Although the political processes and policy outcomes were known ahead of time, as Collier and Mahoney maintain, selecting cases based on their known value on the dependent variable is acceptable if it is the researcher's intent to learn more about a particular case and to provide an alternative, more effective explanation of causal events.<sup>5</sup> In addition, the case of Brazil was used to assess the current GHD literature, explore its limitations and to provide new lessons to help fill lacuna in the literature. In that regard, Brazilian GHD is a crucial case study, where the case was used to examine theoretical frameworks, propose new questions and provide answers.<sup>6</sup>

## GLOBAL HEALTH DIPLOMACY: THEORETICAL ADVANCES AND SHORTCOMINGS

Global Health Diplomacy (GHD) as an analytical concept has recently emerged to conceptualize the marriage of domestic health policy and international diplomacy. Researchers have put forth several definitions of GHD.<sup>7,8,9</sup> For the purposes of theoretical focus and space limitations, this essay will focus on two<sup>10</sup> research areas that scholars have argued best captures the GHD process: government negotiations with state and non-state actors and domestic health policy as a *means* to achieving foreign policy objectives.<sup>11,12,13</sup> In the former, negotiations for achieving health policy goals is the dependent variable of interest, while the latter focuses on health

policy as the means to pursue other foreign policy objectives. Health policy is therefore not the dependent variable of concern.

A large body of research examines the negotiations that states engage in order to achieve domestic and international health policy objectives. One area of research examines government efforts to negotiate and bargain with corporations, such as pharmaceutical companies, to gain access to essential medicines.<sup>14, 15, 16</sup> Here, governments demand access to medicines due to funding shortfalls and strategically use their healthcare needs and capacity to produce generic versions of medicine in order to effectively negotiate and bargain with pharmaceutical corporations for a reduction in prices.<sup>17,18,19</sup> As Katz explains, alternatively, government negotiations can take the form of direct bilateral (between states) and multilateral treaties and agreements between nations within international organizations, such as the World Health Organization (WHO).<sup>20</sup> With regards to bilateral negotiations, states often negotiate with other nations and engage in agreements over the creation of health policy; regarding multilateral negotiations, states work with one another within international institutions in order to establish treaties that bind their commitments to one another, such as the WHO Framework Convention on Tobacco Control (FCTC), ratified in 2003.<sup>21</sup>

Scholars also note that nation states, non-governmental organizations, and international health organizations often negotiate with one another to achieve common health policy goals.<sup>22,23,24,25,26,27</sup> Other scholars examine inter-state negotiations and cooperation not only for collective health but also as mechanisms for creating new forms of global health governance, such as rules and expectations of governing state behavior,<sup>28,29</sup> and strengthening diplomatic ties and international relations,<sup>30</sup> especially within conflict and resource poor settings;<sup>31,32</sup> this definition also includes inter-state negotiations to increase government commitments to global health policy norms, such as access to healthcare and medicine as a human right.<sup>33</sup>

The second reoccurring research area of GHD entails the use of domestic health policy as a *means* to achieve foreign policy objectives, such as national military and economic security, international reputation-building and prestige. This approach therefore entails elements of both hard and soft power, with the latter reflecting a key aspect of the “new diplomacy” in health and development policy.<sup>34</sup> For example, some maintain that nations often provide medical

assistance to other nations in order to increase surveillance of state actors that are perceived as hostile and potentially threatening while building strategic allies, as exemplified by the United States' involvement in Afghanistan and Iraq.<sup>35,36,37,38</sup> Others discuss how nations use bilateral assistance for diseases such as AIDS as a diplomatic tool for building regional stability and growth, curbing the spread of violent extremist activity in fragile states, reducing the need for bilateral assistance while garnering more political allies, and strengthening economic relations.<sup>39</sup> Bilateral assistance in health also enhances national security, as seen with the United States' support for AIDS policies in other countries.<sup>40</sup> Alternatively, as seen in China and Cuba, states have provided medical support and technical assistance in order to obtain access to key resources from other nations, such as oil.<sup>41, 42</sup>

Many scholars have discovered that states provide bilateral medical assistance in order to increase their international reputation and image, in turn contributing to their "soft power" influence.<sup>43</sup> Those nations that have been criticized for their foreign policy decisions, such as engaging in acts of war or committing human rights violations, have often used an increase in bilateral medical assistance in order to restore their reputation and image as benevolent actors.<sup>44, 45, 46, 47, 48, 49</sup> This trend has inspired scholars focused on public relations theory to provide insight into how nations can further advance their image through health diplomacy.<sup>50</sup> A growing body of literature also recognizes how nations' interests in either restoring or enhancing their international image and reputation generates incentives to aggressively respond to domestic health disparities, epidemics, and to create domestic policies with global implications, such as Brazil and India's efforts to work with other nations for universal access to medicine in response to AIDS.<sup>51,52,53,54</sup> Internationally recognized domestic health policies are therefore used as a platform to further a nation's international influence, as seen with Brazil's response to AIDS<sup>55,56,57,58</sup> and tobacco control.<sup>59</sup> Through policy example and reputation, nations can enhance their soft power in global health policy and motivate other nations to mimic their policy responses and to join them in collectively pursuing global health goals.<sup>60</sup>

### *Global Health Diplomacy Shortcomings*

While both of these scholarly camps in GHD processes are important, the case of Brazil's efforts to engage in GHD processes in response to HIV/AIDS suggests that the aforementioned literature has not adequately addressed the historical social and political factors subsequently motivating politicians and health officials to aggressively engage in international health negotiations and cooperation for access to essential medicines. While scholars have analyzed how external pressures from social health movements can motivate governments and domestic agencies to work together to engage in international negotiations with pharmaceutical companies for access to medicines, the case of Brazil helps to emphasize the fact that this literature does not go into much detail when explaining why and where this impetus for collective social pressures and political commitment originates.<sup>61,62</sup> As we will see in Brazil, this impetus may derive from social health movements' historic beliefs that it is the state's responsibility to provide free universal healthcare, as a human right, which entails purchasing and distributing medications for various diseases, including HIV/AIDS. Additionally, this literature does not provide sufficient insight into *how* these social health movements and pressures lead to the creation of domestic institutions and policies that, in turn, essentially force governments to engage in these international activities.

Indeed, we still do not know enough about the historic rise of social health movements, their goals, aspirations, and strategies to pressure and convince the government of the need to guarantee access to medicine. While scholars have addressed the importance of social health movements infiltrating the healthcare bureaucracy to successfully pressure and build a consensus for reform *within* the bureaucracy, little is known about this process when it comes to ensuring access to essential medicines, as well as institutions (e.g., Federal laws) essentially forcing the government to do so.<sup>63</sup> Moreover, we do not know enough about how these institutions induce government officials to engage in aggressive international negotiations to ensure access to medicine and, in the process, maintain their commitment to civil society's healthcare needs. Yet this type of analysis is important for providing a more thorough explanation for why some nations engage in aggressive international negotiations, as well as international cooperation in response to



HIV/AIDS, while others do not. This approach also helps to determine if nations have the historical social and political prerequisites needed to engage in such tactics.

As I discuss shortly, the case of Brazil's response to HIV/AIDS highlights and helps to address this lacuna in the GHD literature. By examining the historic social health movements, mobilization strategies and pressures for universal access to medicine, as well as the creation of a constitution guaranteeing access to healthcare (which includes access to drugs), politicians and health officials were heavily motivated – and to a certain extent, forced – to engage in aggressive international negotiations and cooperation strategies in order to ensure timely and reliable access to ARV medications. By providing this background and discussion of the antecedent domestic politics shaping international negotiation processes, we learn more about why Brazil was so committed and successful in obtaining access to ARV medication.

The case of Brazil also sheds light on another limitation within the aforementioned GHD literature: its reluctance to address how aggressive and successful international negotiations for access to medicines can lead to positive foreign policy externalities. That is, to what extent does a government's success in negotiating with pharmaceutical companies for access to drugs, such as ARV medications, motivate the government to engage in bilateral assistance to other nations? And, why does the government engage in this process?

Similar to the GHD literature mentioned earlier, government leaders often create health policy in order to maintain and increase their international reputation for having a successful public health program. However, while the GHD literature addresses how *domestic* policy interests and geopolitical concerns prompt governments to create policy for these foreign policy goals, we know little about how *international* attention and praise for a nation's international negotiations prompts the creation of domestic bilateral policy-making. Thus, the impetus for using health policy as a means to foreign policy can also come from the international community's praise for a nation's aggressive international negotiation tactics and success in ensuring access to essential medicine.

The case of Brazil provides a good example of how this process can work. By the end of the 1990s, a high level of international praise for the government's success in aggressively bargaining with

pharmaceutical companies to obtain access to medicine, as well as its innovative prevention policies, inspired the government to pursue bilateral policy initiatives. However, it is important to note that most of the international community's praise for Brazil's AIDS program stemmed from its aggressive and successful negotiations with pharmaceutical drug companies for access to medicine.<sup>64</sup> Seeking to maintain and further bolster his government's international reputation and policy influence, President Luiz Inacio "Lula" da Silva worked with the Brazilian Ministry of Health (MOH) and Congress to create new bilateral initiatives that could help several African nations build the capacity needed to produce their own generic versions of ARV medication and engage in international negotiations with pharmaceutical companies.

### **BRAZILIAN INTERNATIONAL HEALTH NEGOTIATIONS AND COOPERATION**

Brazil has a long history of aggressively negotiating with non-state actors to achieve the government's and other nations' health policy goals. In response to growing HIV/AIDS cases, after working with the MOH to pass legislation guaranteeing universal access to antiretroviral (ARV) medication through Federal law #9313 in 1996, the director of the national AIDS program, Paulo Teixeira, worked closely with other nations to increase access to ARV medication. After extensive negotiations and meetings, in 2001 Teixeira met with health ministers in Doha, Qatar to create a "declaration" stating that all developing nations had the right to produce generic versions of ARV medications in times of health crisis.<sup>65</sup> Teixeira worked closely with his counterpart from India and other developing nations to build a coalition supporting this statement.<sup>66,67</sup> As Teixeira explains, his efforts reflected the Brazilian government's long-held belief in ensuring universal access to medicine as a human right.<sup>68</sup>

Since the 2001 Doha declaration, MOH officials have taken advantage of the 1996 TRIPS ruling stating that in times of health crisis, nations have the right to issue compulsory licenses for the production of ARV medication. Possessing strong pharmaceutical capacity, which reflects a long history of state investment in pharmaceutical technology and drug production,<sup>69</sup> on several occasions Brazil's MOH has aggressively bargained with pharmaceutical companies, such as Abbot and Roche, and threatened



some with compulsory licenses in order to get lower prices for ARV medication.<sup>70</sup>

For example, from 2000 to 2004, after extensive bargaining the government was able to obtain a reduction in price for the three most important ARV medicines for drug cocktails: Merck's *Efavirenz* was reduced by 73%, Abbot's *Lopinavir/Ritonavir* by 56.2%, and Roche's *Nelfinavir* by 73.8%.<sup>71,72</sup> In addition, during this period Gilead's *Tenofovir* was sold in Brazil for 43.6% less than US market prices, while Bristol-Myer's *Atazanvir* was sold in Brazil for 76.4% less than US prices.<sup>73,74</sup> Brazil's threats have been so effective that it did not have to actually issue a compulsory license until May of 2007, for the production of Merck's *Efavirenz*.

Brazil's aggressiveness in international negotiations was further illustrated by Julian Assange's *WikiLeaks* revelations. On December 16, 2010, Assange's website posted several Brazilian embassy cables highlighting the government's strategies to further threaten pharmaceutical companies for a reduction in ARV prices. In fact, in one cable, the Ambassador of Brazil's Ministry of Foreign Affairs, Clodoaldo Hugueney, supposedly met with the US Ambassador in Brasília in 2005 to warn him that US pharmaceutical companies should lower their prices for ARV medication or else face the specter of either compulsory licenses or the passage of new bills forbidding future patent recognition for ARV medicines.<sup>75</sup> Interestingly it was also revealed that the US embassy in Brasília was used as a negotiating forum between the Brazilian government and US pharmaceutical companies.<sup>76</sup> The cable went on to claim that Ambassador Hugueney hinted that the Chamber of Deputy's interest in passing these bills depended on how responsive and willing US companies were to lower prices.<sup>77</sup>

Lula also engaged in other tactics to anticipate and strengthen his negotiating capabilities. In 2003, for example, he signed a presidential decree order that amended Article 71 of the 1996 Patent Law for medications; this patent law regulated the issuance of patent licenses. According to this amendment, also referred to as Amendment 10, whenever domestic pharmaceutical producers could no longer produce a particular ARV medication, the government allowed for the importation of generic medications.<sup>78</sup> Amendment 10 also stated that the government would allow this to occur even if it was deemed in the "public's interest" to do so.<sup>79</sup> Furthermore, Article 10 allowed the government to no longer wait on international

pharmaceutical companies' consent before importing generics.<sup>80</sup> This further increased the threat posed to pharmaceutical companies, as well as the MOH's bargaining power. While apparently MOH officials were not interested in issuing compulsory licenses, information obtained from *WikkiLeaks* cables nevertheless revealed that they were more than ready and willing to do so, if need be.<sup>81</sup>

Brazil also has a long history of international health cooperation. Since the early 20<sup>th</sup> century, scholars note that, in order to eradicate syphilis, TB, and malaria, public health officials in the cities of Rio de Janeiro and São Paulo worked closely with scientists in Western Europe as well as American philanthropists, such as the David Rockefeller and Irene Diamond Foundations.<sup>82,83</sup> International health cooperation declined somewhat under the Getulio Vargas dictatorship (1930-45), save for Brazil's involvement in the formation of the World Health Organization (WHO) in San Francisco in 1946, and declined as well during Brazil's military governments (1964-85) and Brazil's first two conservative democratic presidencies (1986-94).<sup>84</sup> The government nevertheless re-engaged in international health cooperation under the Fernando H. Cardoso administration (1994-2002). Under Cardoso, the government became highly proactive and visible in their response to disease, especially HIV/AIDS.<sup>85,86</sup>

Indeed, the Cardoso administration initiated several policies focused on increasing the government's cooperation with the international community in response to AIDS. The first endeavor came with the creation of the Foreign Cooperation Unit, also known as *Coopex*, in 1995. *Coopex* was a direct response to a consensus created by several nations at a conference held earlier that year suggesting the creation of the *Group for Horizontal Technical Cooperation on HIV/AIDS* (GCTH).<sup>87</sup> At this meeting, 21 nations agreed on the need for greater international cooperation in response to the epidemic, mainly by way of technical resources, sharing experiences and policy recommendations.<sup>88</sup> Through *Coopex*, Brazil's national AIDS program began to explore ways of providing technical training and support to help other nations in the region.<sup>89</sup>

Later in 2002, Cardoso authorized the creation of the *International Cooperation Program for the Control and Prevention of HIV in Developing Nations* (PCI). Through PCI, Brazil's national AIDS program began to provide azidothymidine (AZT), an antiretroviral medication, to several nations throughout Latin

America, including El Salvador, Bolivia, Paraguay, the Dominican Republic, and Colombia, followed by assistance to several African nations, such as Mozambique, Burkina Faso, St. Thomas and Prince, and Cape Verde.<sup>90</sup> Despite PCI's creation, *Coopex* was still responsible for implementing the national AIDS program's international cooperation projects.<sup>91</sup>

### *History, Social Movements, and Bureaucratic Infiltration*

But why has Brazil engaged in these international negotiation and cooperation strategies? This response was mostly shaped by the proactive efforts and presence of a social health movement seeking to gradually transform the government's interest and commitment to providing high quality universal healthcare. Known as the *movimento sanitarista* (sanitarium movement), during the 1960s a group of university intellectuals, doctors, healthcare workers and politicians created a social movement dedicated to strengthening the public sector in healthcare provision through a more equitable and effective healthcare system. The *sanitaristas* believed that the military government's health policies were narrowly focused on government employees and the employed formal sector. In response, they proposed a healthcare system that extended services to the poor in a decentralized participatory approach, with an emphasis on preventative care.<sup>92</sup> Above all, the focus was on strengthening the government's commitment and capacity to provide universal healthcare.

To achieve their goals, the *sanitaristas* gradually infiltrated the highest echelons of the national healthcare and planning agencies.<sup>93,94</sup> Beginning in the 1970s, key leaders of the *sanitarista* movement were also allowed to work in important positions within the MOH, while working in government-approved think tanks to formulate policy.<sup>95</sup> Their infiltration of the bureaucracy was aided by military officials who believed that their presence helped legitimize the state, given the *sanitaristas'* proclaimed commitment to universal healthcare.<sup>96</sup> While working within the bureaucracy, Falleti writes that *sanitarista* leaders helped to build a political consensus on the need to draft into the constitution a new universal healthcare system.<sup>97</sup> After presenting their ideas at a national conference held in Brasília in 1986, the *sanitaristas* succeeded in convincing the drafters of the new democratic constitution to include within it the *Sistema Único de*

*Saúde* (SUS). Through SUS, the constitution guaranteed that every citizen had a right to healthcare, which included access to essential medicines and treatment.

Many of the *sanitaristas* that successfully fought for SUS also worked within the national AIDS program shortly after its inception in 1986.<sup>98</sup> Many came from state health departments and had extensive experience working on sub-national AIDS programs.<sup>99,100,101</sup> While being essentially ignored under the democratic conservative administrations of José Sarney (1986-90), Fernando Collor de Mello (1990-92), and to a certain extent Itamar Franco (1992-94), under Fernando H. Cardoso (1994-2002), the *sanitaristas* succeeded in creating a bureaucratic and congressional consensus for the creation of HIV/AIDS legislation mirroring SUS and its universal principles.<sup>102</sup> In 1996, the *sanitaristas* turned-AIDS officials also succeeded in helping garner congressional approval for Federal law #9313, which, as mentioned earlier, legally guaranteed universal access to ARV medication.

It was the gradual infiltration of *sanitarista* principles and their institutionalization through Federal constitutional law, in addition to a challenging fiscal environment, that motivated the MOH to engage in international negotiations for access to ARV medicine.<sup>103</sup> Facing austere budget cuts amidst an economic fiscal stabilization program called the *Plano Real*, the realization that the MOH may not be able to afford the ongoing provision of ARV medications essentially forced MOH officials to begin working with other nations to declare access to ARV medicine a human right. At the same time, and as mentioned earlier, the MOH began to threaten pharmaceutical companies with the production of generic ARV medication unless they lowered their prices.<sup>104</sup> The government's preexisting legal and constitutional commitments guaranteeing the universal provision of medication (e.g., Federal law #9313) left no other option but for MOH officials to pursue this strategy.

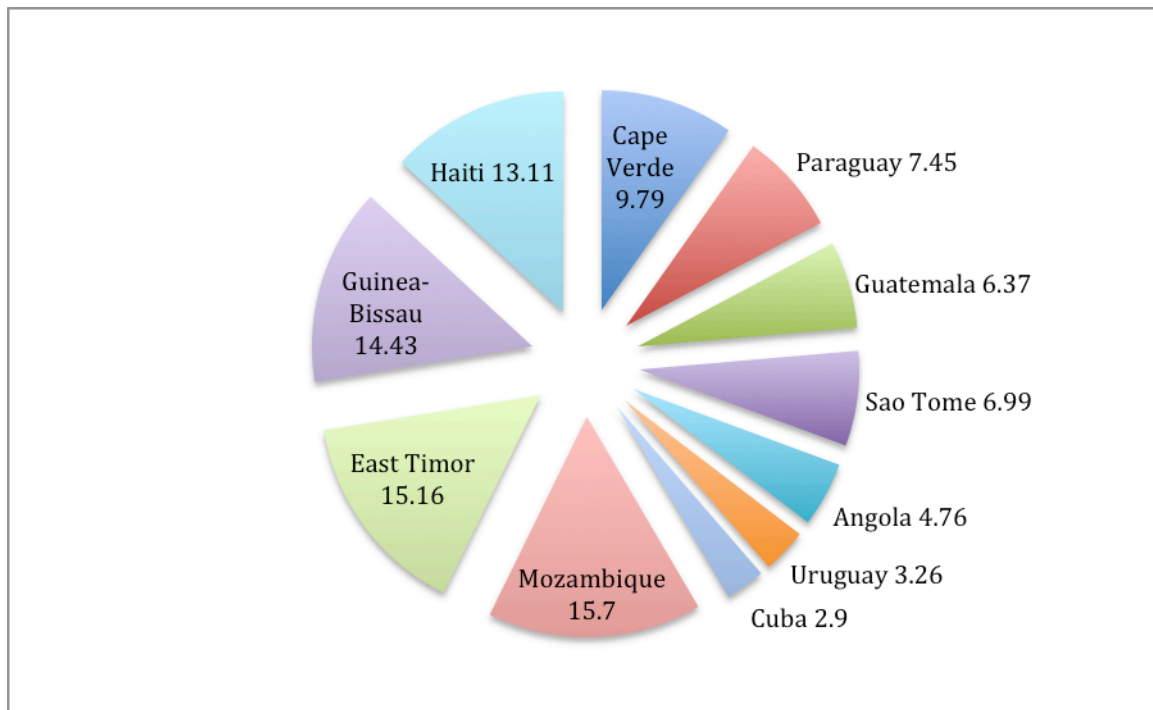
### *Providing Bilateral Assistance*

In addition to securing the provision of ARV medication, there were the other potential externalities associated with the government's aggressive international negotiations. A key externality that arose was the government's motivation to engage in new bilateral

aid initiatives. Indeed, these efforts heightened under the Lula administration.<sup>105,106,107</sup>

For example, beginning in 2003, Lula worked closely with the Ministry of Foreign Affairs (MFA), the *Agencia Brasileira de Cooperação* (ABC), as well as the MOH, to provide technical assistance to other nations confronting the AIDS epidemic.<sup>108,109,110</sup> That year, the country of Mozambique approached Brazil's MOH to obtain technical assistance in producing generic versions of ARV medication.<sup>111</sup> Mozambique did this because of Brazil's national AIDS program's international reputation for successfully producing and distributing ARV medication.<sup>112</sup> In October 2003, the MOH and ABC agreed to provide technical support to Mozambique's MOH to construct a pharmaceutical plant for the production of ARV medication.<sup>113,114,115,116</sup> ARV drugs created at the plant would then be distributed to other African nations.<sup>117,118,119,120</sup>

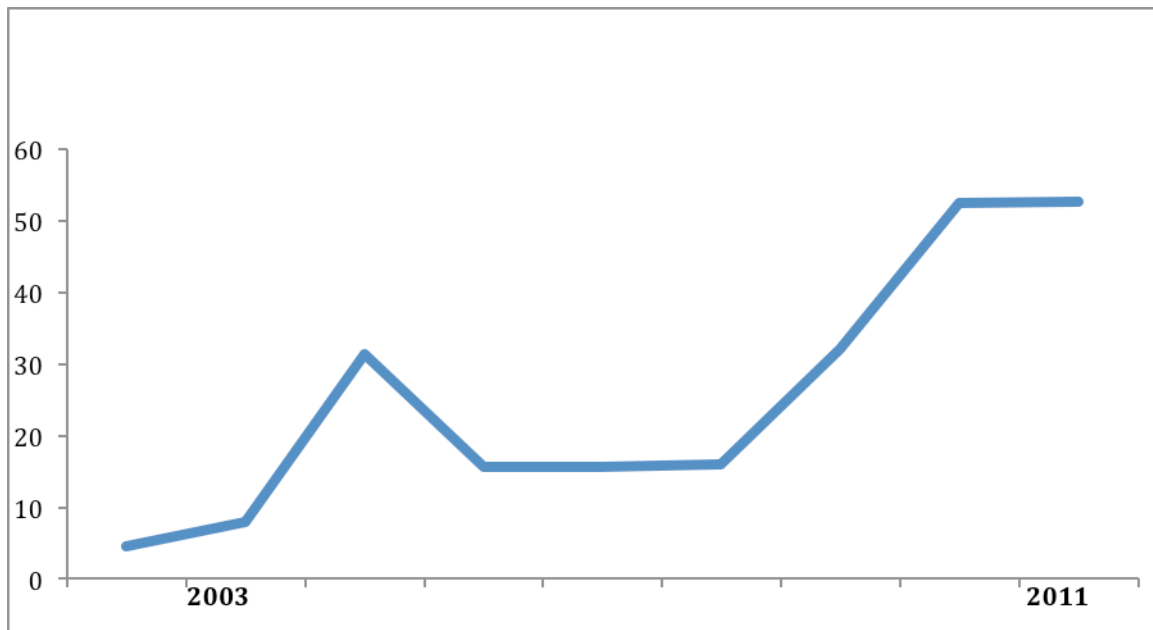
**Figure 1: Developing Countries Receiving Brazilian Technical Assistance (USD % of total budget, 2005-2010)**



The ABC and MOH's strategy in bi-lateral assistance was not to provide a large amount of funding but rather to provide technical assistance and knowledge on how to produce ARV medication in a

sustainable manner.<sup>121,122,123</sup> This was emblematic of Brazil’s general approach to health diplomacy, which focused on helping other nations learn and develop, from their own resources, the knowledge and experience needed to create self-sustaining institutions and programs.<sup>124</sup> To achieve this, health scientists from FIOCRUZ, a Federal public health university in Rio de Janeiro, went to Mozambique to provide training on how to construct the labs, as well as the types of technology and researchers needed.<sup>125,126,127</sup> Health officials from Mozambique were also sent to Brasília and Rio de Janeiro for training.<sup>128</sup> The pharmaceutical plant – also known as “mini-FIOCRUZ” – was to be open and operational by 2010. However, there was a delay in opening the lab, which upset Lula because of his personal interest in Mozambique.<sup>129</sup> Lula quickly blamed the ABC for the delay.<sup>130</sup>

**Figure 2: Brazilian Annual Budget for Technical Assistance to Developing Nations (All policy sectors, USD millions, 2003-2011)**

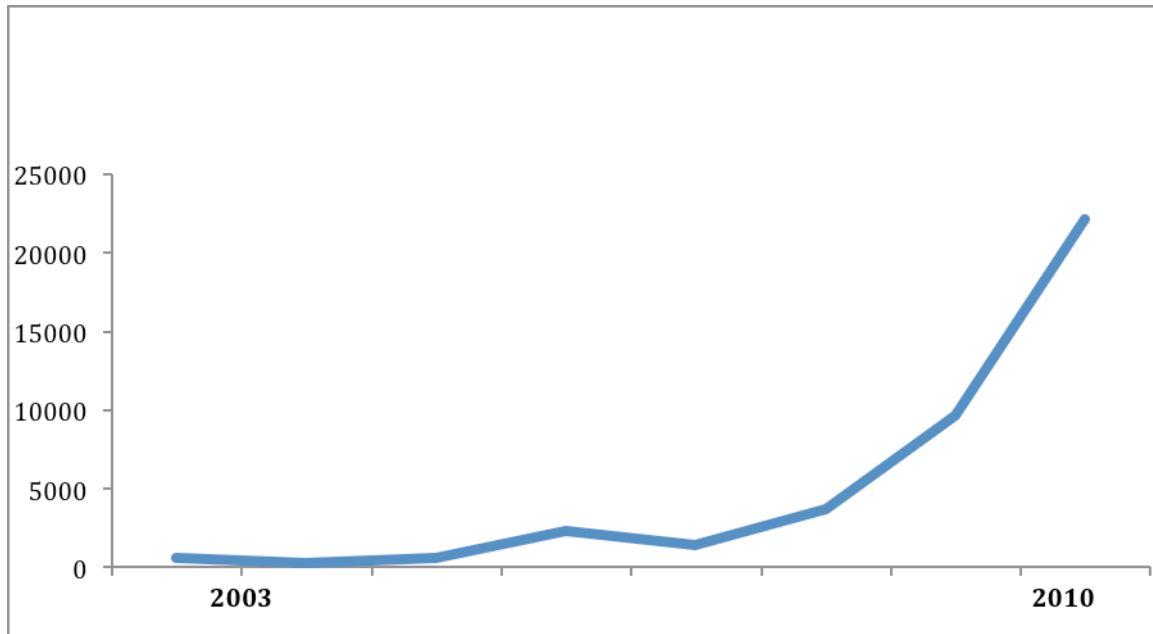


But Mozambique was not the only nation that Brazil assisted. In 2005, Lula met with the President and MOH officials in Nigeria to help construct a pharmaceutical plant for ARV.<sup>131</sup> Brazil’s national AIDS program once again offered to provide technical training to healthcare workers based on the *Far-Manguinho’s* model of ARV



production, as well as training on disease monitoring and supply chain management.<sup>132,133</sup> In 2007, the Lula administration responded to Angola's request for constructing a pharmaceutical lab for ARV production.<sup>134,135,136</sup> Brazilian health officials also planned to create another "mini-FIOCRUZ" in Angola, similar to Mozambique's.<sup>137</sup>

**Figure 3: Brazilian Annual Budget for Technical Assistance to Africa (All policy sectors, USD millions, 2003-2010)**



In addition to helping other nations construct labs, Lula also increased the amount of international technical assistance provided for strengthening AIDS programs in other nations. In 2005, Lula created a new center within the MOH's national AIDS program, the *International Center for Technical Cooperation for HIV/AIDS Initiatives* (ICTS). This center was established with the support of the Brazilian MOH and other multi-lateral and bi-lateral agencies, such as UNAIDS, the UK Department for International Development (DFID), and Germany's Department for International Development (GZT). ICTS was created in order to provide technical assistance to other nations in their efforts to strengthen their national AIDS program, with an emphasis on creating *sustainable* and enduring AIDS policies.<sup>138</sup>

The ICTS had several strategies: identify projects and programs for horizontal technical cooperation for AIDS in order to meet the

needs of developing nations; create, monitor, and promote partnerships with governments and NGOs; implement technical cooperation projects that facilitate the creation of sustainable and enduring capabilities, which will help provide a more effective response to AIDS; disseminate lessons in order to share good policy practices; and finally, raise and provide financial, technical, and human resources so as to strengthen the ICTS's ability to provide assistance.<sup>139</sup>

From 2002-2009, Moura Santos Lima and Pires de Campos also found that the national AIDS program engaged in approximately 29 projects focused on providing technical assistance for AIDS.<sup>140</sup> A large amount of assistance went to AIDS prevention policies and health systems strengthening. For example, the *Harmonization of Policies for Sexual Education, HIV/AIDS Prevention, and Drugs in the School Environment* aid was provided to the nations of Argentina, Chile, Paraguay, Peru, and Uruguay, with financial support from GTZ, UNAIDS, UNESCO, UNFPA, and DFID.<sup>141</sup> In addition, the ICTS program's *Strengthening Programs for the STD/HIV/Aids Prevention, Surveillance, Full Assistance and Human Rights in Cities within the MERCOSUR, for the nations of Venezuela, Colombia, Peru, Bolivia, Argentina, Paraguay, and Uruguay*, as well as the program titled *Responding to the Vulnerabilities of Street-Dwelling Youth: The South-South Cooperation as an Axis of Integration*, were supported by the Netherlands' Embassy and UNICEF.<sup>142</sup>

The national AIDS program also continued to distribute ARV medications to several nations throughout Latin America and Africa. By far most of the medications have gone to the African nations of Botswana, Burkina-Faso, Cape Verde, Ghana, Guinea-Bissau, Mozambique, Kenya, St. Thomas and Prince, Tanzania, and Zambia; while in Latin America, they have gone to Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Dominican Republic, Argentina, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Suriname, Uruguay, and Venezuela.<sup>143</sup> Finally, the national AIDS program also started working with Caribbean nations on issues such as the monitoring of social and reproductive rights on AIDS and on the control of AIDS among armed and police forces in Latin America and the Caribbean.<sup>144</sup>

Interestingly, after conducting an extensive analysis of the Brazilian national AIDS program's technical assistance, Moura Santos Lima and Pires de Campos found that the bulk of these initiatives

were targeted at helping developing nations strengthen their health systems capacity to respond to AIDS.<sup>145</sup> They found that for the 2002-09 period, approximately 78% of all technical assistance went to this initiative; 5.8% to providing ARV medication; and the remaining amount towards programs increasing Brazil's integration into the international community, such as the program titled *Strengthening Brazil's Insertion and Consolidation into the Global Health Scenario*.<sup>146</sup> The latter included initiatives such as strengthening the response to AIDS on country borders; strengthening cooperation networks; and finally, supporting countries applying for the Global Fund to Fight HIV/AIDS, TB, and Malaria.<sup>147</sup>

### *The Geopolitics of Bilateral Assistance*

But why did the government provide this bilateral assistance? In large part, this policy response occurred in an attempt to further increase the national AIDS program's international reputation and policy influence. Here, international praise for the government's aggressive and successful international negotiations for ensuring access to ARV medications motivated the government to maintain and deepen its strong international reputation and influence, in turn kindling efforts to create bilateral policies that could achieve this goal.

Indeed, by the early 2000s, the international community began to notice Brazil's successful response to AIDS. Because of its innovative and successful treatment program, as well as a host of prevention policies, in 2003 Brazil became the first nation to win the Bill and Melinda Gates Foundation award for having the best model response to AIDS.<sup>148</sup> In addition to prevention, the government was praised for its ability to guarantee access to ARV medications, which, as noted earlier, was the result of the MOH's aggressive negotiations with the pharmaceutical industries.<sup>149, 150</sup> What's more, two years later, in 2005, Peter Piot, then-Director of UNAIDS, stated at a conference that Brazil had the best model response to AIDS and that other nations should work to emulate it.<sup>151</sup> A myriad of academic journal articles, magazines and news articles arose supporting these claims.<sup>152</sup>

Upon entering office, Lula became aware of the national AIDS program's success and international acclaim in aggressively negotiating with pharmaceutical companies. He sought to maintain Brazil's international reputation as a nation fully committed and

successful in responding to AIDS. To achieve this, Lula sought to create policies helping other nations respond to the epidemic.<sup>153,154,155</sup> In an interview with the former director of the national AIDS program, Paulo Teixeira, he explained that Lula was aware of the program's international recognition and fame, often calling Teixeira into his office to learn more about the AIDS program and its success.<sup>156</sup> Scholars and government officials also note that soon after entering office, Lula arranged meetings with MFA diplomats and MOH officials to see how they could use this international attention and fame as an opportunity to introduce new legislation for providing bilateral assistance.<sup>157</sup>

As a leader of an emerging nation, Lula was also motivated by his interest in strengthening Brazil's overall reputation, as a nation that was both capable and politically committed to eradicating AIDS.<sup>158,159</sup> International reputation-building was of keen interest, because of the government's acknowledgement of its rich history of international cooperation in combating disease, and because of its committed to the 2001 UNAIDS resolution for accessing ARV medication as a human right.<sup>160,161</sup> This interest intensified under Lula.<sup>162,163</sup>

In fact, Lula endorsed and was involved with the national AIDS program's partnership with the MFA to promote the AIDS program's success at international organizational meetings and conferences.<sup>164</sup> Perhaps more so than Cardoso, Lula was unwaveringly committed to furthering Brazil's reputation and image as having the world's best response to AIDS, a nation that could join the advanced industrialized nations in having the capacity to effectively contain the epidemic.<sup>165,166</sup>

By creating bilateral initiatives with the goal of furthering Brazil's international reputation, Lula was also able to increase Brazil's presence and international agenda-setting influence.<sup>167,168,169</sup> During his administration, Lula, as well as requesting MFA and MOH diplomats, repeatedly traveled to international meetings and conferences and referred to the success of his program's various bilateral assistance and cooperation policies.<sup>170</sup> By repeatedly showing how and why Brazil's prevention and treatment policies were successful through the display of epidemiological data, the government became influential during policy discussions at meetings at the United Nations.<sup>171,172</sup>

Brazil's increased international influence was also exhibited by the sheer number of requests that the government has had to assist in crafting policy at the international, regional, and domestic level. For instance, because of the government's well-known international success, WHO and UNAIDS officials have repeatedly approached Brazilian AIDS officials for assistance in devising new policies geared towards helping developing nations implement prevention and treatment programs.<sup>173</sup> In addition, delegates from regional health organizations, such as Pan-American Health Organization (PAHO), have consistently requested the support of Brazilian AIDS officials. Finally, as mentioned earlier, since the early 2000s several African nations have approached the MOH for assistance in constructing pharmaceutical labs and producing generic versions of ARV medication.<sup>174,175,176</sup>

## CONCLUSION

Despite several recent advances in conceptualizing and clarifying the definition of Global Health Diplomacy (GHD), the case of Brazil sheds light on issues that to date still have not been adequately addressed. This suggests that more work needs to be done in evaluating GHD concepts and definitions with detailed qualitative case study evidence. For, as John Walton maintains, the processes of defining and refining theoretical concepts, causal mechanisms, and case studies is an ongoing process that entails the incessant interaction of theory and evidence.<sup>177</sup>

Indeed, while one area of the GHD literature has emphasized the importance of bilateral and multilateral negotiations for achieving domestic and international health policy needs, studies have not adequately addressed the complexity of the historical social and political factors motivating governments to engage in international negotiations for access to medicines, as well as international cooperation strategies. Nevertheless, the case of Brazil's response to HIV/AIDS helps illuminate this process. This case study has revealed that in order to better understand why governments are highly aggressive and successful in their negotiations with pharmaceutical companies for access to ARV medications, one must first understand the historic rise and mobilization strategies of social health movements as well as the creation of institutions that undergird their interests.



During the 1980s, the *sanitarista* movement gradually occupied prominent positions within the national health bureaucracy, advocating principles of access to healthcare as a human right. Eventually, because of their efforts, Federal law #9313 was created in 1996, which mandated that the government universally distribute medications to all in need. In turn, this law essentially forced politicians to engage in intensive inter-state negotiations with pharmaceutical companies for access to ARV medication. By guaranteeing access to medicine, as well as having a progressive prevention program, the national AIDS program's international recognition and fame increased. By the early-2000s, this fame motivated President Luiz Inacio Lula da Silva to take advantage of this attention and to create bilateral policies further increasing Brazil's international reputation and influence in international agenda setting and policy-making. By helping several African nations develop the pharmaceutical capacity needed to produce generic versions of ARV medication, these African nations are also developing the knowledge and experience needed to effectively bargain with pharmaceutical companies for access to medicine. This is a form of technical assistance that has bolstered Brazil's reputation as a world leader in helping other nations combat AIDS.

The case of Brazil therefore suggests that future research examining GHD international negotiation processes, policy and health outcomes may benefit from providing a more thorough analysis of the historic social health movements and strategies *within* the bureaucracy and how this, in turn, can amplify government commitments to AIDS. While scholars have addressed the importance of social health movements in applying pressures *outside* of the government for access to medical treatment in response to AIDS, the case of Brazil shows that more needs to be done analyzing how and to what extent social health movements gradually occupy positions within the bureaucracy and assessing their capacity to build a coalition for reform from within.<sup>178,179</sup>

Second, the case of Brazil also underscores the importance of addressing the positive externalities of a nation's success in engaging in international negotiations for access to ARV medication in terms of creating new bilateral initiatives helping nations combat AIDS. While the GHD literature has addressed the domestic geopolitical incentives to creating bilateral assistance programs in order to boost a nation's international reputation and influence, little is known about how the



international community's attention and acclaim for a nation's success in international negotiations can incentivize governments to provide bilateral assistance.

Therefore, in contrast to the aforementioned GHD literature emphasizing the creation of bilateral health policies as a means to increasing a nation's foreign policy objectives, the case of Brazil shows that the impetus for bilateral policy reform often resides at the international level. Future work will need to examine if the international community has praised other nations for their aggressive international negotiations and if this has led to new bilateral initiatives.

Other important lessons emerge from Brazilian GHD processes. One that the literature seems to have overlooked is the importance of international fame as a catalyzing force. That is, how does an international community's praise for a nation's successful international negotiations and cooperation strategies prompt government officials to pursue new policy reforms? As I discussed earlier, in the GHD literature international fame is often treated as an outcome to be explained, where health policy is created in order to increase a nation's international reputation, fame and influence. Other scholars have instead used statistical analysis to validate the strong international reputation and fame that some nations have obtained for their policy response to HIV/AIDS.<sup>180</sup> However, scholars to date have not considered how international fame can also act as a catalyst and incentive for policy reforms. For as we saw in Brazil, international fame (a by-product of Brazil's successful international negotiations, as well as its innovative prevention programs) can incentivize presidents and health officials to work together in creating policies (such as bilateral initiatives) that reinforce and sustain the government's international reputation and influence. Future research will therefore need to examine the effects and long-term policy consequences of international fame.

Finally, scholars may wish to consider how international fame provides *ongoing* incentives for HIV/AIDS policy innovation and sustainability. Government interest in sustaining their international fame may unmask the government's efforts to become more influential in the international policy-making community.<sup>181</sup> Periodic international recognition and fame, by way of positive statements from international health organizations, media attention, and scholarly research, may feed domestic political desires to sustain a

nation's fame by creating more innovative policies for combating disease. This results in an interactive, self-reinforcing counter-reactionary sequence, whereby each step along the policy path leads to a counter-reaction by the international community, followed by a domestic counter-policy reaction (denoted by the dotted arrow line), ultimately leading to sustainable and innovative policy responses to disease, which is the ultimate outcome of concern. This process is similar to what Mahoney describes as a counter-reactionary causal sequence, where actors continuously and positively counter-react to the preceding policy decision, which in turn leads to a self-reinforcing chain reactionary sequence and path dependency.<sup>182</sup> Future research will therefore need to demarcate and underscore the different phases of international recognition and fame and how this continues to generate incentives for domestic policy innovation and sustainability in response to HIV/AIDS and other diseases.

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Others areas of GHD research include: informal diplomatic relations between doctors, NGOs, and governments; health policy as a means to develop trust and diplomacy between nations; health policy as a means to develop peace and security between nations; public-private partnerships, e.g., between nations and pharmaceutical corporations; advocating health goals through foreign policy; and how inter-state negotiations over health policy can benefit from the expertise of skilled diplomats in ministries of foreign relations.

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